

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4985

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04955

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Marion Station</b>		c. LENGTH OF STAY IN 1b <b>Lifetime</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Old State Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>FREDERICK THOMAS ADAMS</b>		4. DATE OF DEATH <b>April 7, 1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 31, 1871</b>
9. AGE (In years last birthday) <b>89</b> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer &amp; Canner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm &amp; Canning</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Samuel T. Adams</b>	
14. MOTHER'S MAIDEN NAME <b>Mary Whittington</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Austin Whittington, Jr., Marion Station, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Occlusion</b> Conditions, if any, which gave rise to immediate cause (b) <b>Sudden</b> (c) <b>420.1</b> DUE TO <b>Sudden</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Subject found dead sitting in chair by nephew</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>None</b>		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>W. H. Coulbourn</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>William H. Coulbourn, M. D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/9/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Paul's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Marion Station, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons, Crisfield, Maryland</b>		24a. REC'D BY REGISTRAR <b>APR 14 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

420.1

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

Item 7 Film G262 5/4/60 iwk

4986

## CERTIFICATE OF DEATH

Reg. Dist. No.

64956

1. PLACE OF DEATH o. COUNTY <b>SOMERSET</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>SOMERSET</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pocomoke City, Md</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Pocomoke City</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>HOME</b>				d. STREET ADDRESS <b>RED #1, Box 53</b>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>P. BALLARD</b> Last				4. DATE OF DEATH Month <b>APRIL</b> Day <b>16</b> Year <b>1960</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>COL</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JAN 7, 1897</b>	
9. AGE (In years lost birthday) yrs. <b>63</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FACTORY WORK</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A</b>	
13. FATHER'S NAME <b>LAFAYETTE BALLARD</b>				14. MOTHER'S MAIDEN NAME <b>ELISHA MILLS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>215-26-4489</b>		17. INFORMANT <b>Alexander Ballard, Pocomoke, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b> <b>331 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Atherosclerosis</b> DUE TO (c) <b>Essential Hypertension</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2 wks.</b> <b>2 yrs.</b> <b>2-3 yrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Semility</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>4-2-</b> 19 <b>60</b> , to <b>4-16-</b> 19 <b>60</b> , that I last saw the deceased alive on <b>4-16-60</b> , 19 <b>60</b> , and that death occurred at <b>6 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Reed A. Duveney M.D.</b>				ADDRESS (Street, city or town, state) <b>801-4th St, Pocomoke</b>			
DATE SIGNED <b>4-23-60</b>							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>4-23-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>CHRIST'S CEM</b>		22d. LOCATION (City, town, or county) (State) <b>Pocomoke City, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edgar Whorton - new church, Va.</b>				24a. REC'D BY REGISTRAR DATE <b>APR 26 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knap</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4987

## CERTIFICATE OF DEATH

04957

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Somerset</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rumbley</b>				c. LENGTH OF STAY IN 1b <b>83 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Virgie</b> Middle <b>Blake</b> Last				4. DATE OF DEATH Month <b>April</b> Day <b>1</b> Year <b>1960</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 11, 1876</b>	
9. AGE (In years last birthday) <b>83</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Thomas J. Blake</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Hewitt</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>no</b>			
17. INFORMANT <b>Mr Thomas M. Blake</b>				Address <b>Rumbley, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> <b>420, 1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>6-14-58</b> , 19____, to <b>4-1-60</b> , 19____, that I last saw the deceased alive on <b>3-31-60</b> , 19____, and that death occurred at <b>6A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Princess Anne, Maryland</b> DATE SIGNED _____ ACTUAL SIGNATURE <b>Everett C. Sutter</b> M.D. PHYSICIAN'S NAME (Type) <b>Everett C. Sutter MD</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-3-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Blake Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Rumbley, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Learn H. Wilson</b>				ADDRESS <b>Princess Anne, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>APR 5 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thane</b>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

1937

DATE OF DEATH		PLACE OF DEATH	
JAN 10 1937		BALTIMORE	
AGE		SEX	
67 YEARS		MALE	
RACE		COLOR	
WHITE		WHITE	
EDUCATION		OCCUPATION	
HIGH SCHOOL		LABORER	
MARRIED		SINGLE	
YES		NO	
NAME OF DECEASED		NAME OF DECEASED	
JOHN W. BROWN		JOHN W. BROWN	
ADDRESS		ADDRESS	
1234 E. BALTIMORE		1234 E. BALTIMORE	
CITY		CITY	
BALTIMORE		BALTIMORE	
STATE		STATE	
MD		MD	
CAUSE OF DEATH		CAUSE OF DEATH	
HEART DISEASE		HEART DISEASE	
MANNER OF DEATH		MANNER OF DEATH	
NATURAL		NATURAL	
DATE OF BURIAL		DATE OF BURIAL	
JAN 12 1937		JAN 12 1937	
PLACE OF BURIAL		PLACE OF BURIAL	
BALTIMORE		BALTIMORE	
CITY		CITY	
BALTIMORE		BALTIMORE	
STATE		STATE	
MD		MD	
NAME OF FUNERAL HOME		NAME OF FUNERAL HOME	
JOHN W. BROWN		JOHN W. BROWN	
ADDRESS		ADDRESS	
1234 E. BALTIMORE		1234 E. BALTIMORE	
CITY		CITY	
BALTIMORE		BALTIMORE	
STATE		STATE	
MD		MD	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4988

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

64958

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Princess Anne R. F. D.</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charlotte Lenora Corbin</u>				4. DATE OF DEATH Month Day Year <u>April 9 1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Black</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 13, 1959</u>	9. AGE (In years last birthday) yrs. <u>4</u>	IF UNDER 1 YEAR Months <u>4</u> Days <u>26</u>	IF UNDER 24 HRS. Hours <u>26</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baby</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>Sylvester Corbin</u>			14. MOTHER'S MAIDEN NAME <u>Bessie King</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Bessie Corbin (Mother) Princess Anne R. F. D.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Bronchitis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>R. H. Johnson</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>R. H. Johnson</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/10/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Mark</u>		22d. LOCATION (City, town, or county) (State) <u>Oakville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William H. Stancey</u>				24a. REC'D BY REGISTRAR DATE <u>APR 20 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton S. Frank</u>	

2082279XV.5

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED _____		2. SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		3. AGE _____	
4. DATE OF DEATH _____		5. TIME OF DEATH _____		6. PLACE OF DEATH _____	
7. OCCUPATION _____		8. CAUSE OF DEATH _____		9. MANNER OF DEATH <input type="checkbox"/> ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> NATURAL	
10. SIGNATURE OF MEDICAL EXAMINER _____		11. SIGNATURE OF WITNESS _____		12. SIGNATURE OF DECEASED _____	
13. DATE OF EXAMINATION _____		14. TIME OF EXAMINATION _____		15. PLACE OF EXAMINATION _____	
16. SIGNATURE OF DECEASED _____		17. SIGNATURE OF WITNESS _____		18. SIGNATURE OF MEDICAL EXAMINER _____	
19. DATE OF EXAMINATION _____		20. TIME OF EXAMINATION _____		21. PLACE OF EXAMINATION _____	
22. SIGNATURE OF DECEASED _____		23. SIGNATURE OF WITNESS _____		24. SIGNATURE OF MEDICAL EXAMINER _____	
25. DATE OF EXAMINATION _____		26. TIME OF EXAMINATION _____		27. PLACE OF EXAMINATION _____	
28. SIGNATURE OF DECEASED _____		29. SIGNATURE OF WITNESS _____		30. SIGNATURE OF MEDICAL EXAMINER _____	
31. DATE OF EXAMINATION _____		32. TIME OF EXAMINATION _____		33. PLACE OF EXAMINATION _____	
34. SIGNATURE OF DECEASED _____		35. SIGNATURE OF WITNESS _____		36. SIGNATURE OF MEDICAL EXAMINER _____	
37. DATE OF EXAMINATION _____		38. TIME OF EXAMINATION _____		39. PLACE OF EXAMINATION _____	
40. SIGNATURE OF DECEASED _____		41. SIGNATURE OF WITNESS _____		42. SIGNATURE OF MEDICAL EXAMINER _____	
43. DATE OF EXAMINATION _____		44. TIME OF EXAMINATION _____		45. PLACE OF EXAMINATION _____	
46. SIGNATURE OF DECEASED _____		47. SIGNATURE OF WITNESS _____		48. SIGNATURE OF MEDICAL EXAMINER _____	
49. DATE OF EXAMINATION _____		50. TIME OF EXAMINATION _____		51. PLACE OF EXAMINATION _____	
52. SIGNATURE OF DECEASED _____		53. SIGNATURE OF WITNESS _____		54. SIGNATURE OF MEDICAL EXAMINER _____	
55. DATE OF EXAMINATION _____		56. TIME OF EXAMINATION _____		57. PLACE OF EXAMINATION _____	
58. SIGNATURE OF DECEASED _____		59. SIGNATURE OF WITNESS _____		60. SIGNATURE OF MEDICAL EXAMINER _____	
61. DATE OF EXAMINATION _____		62. TIME OF EXAMINATION _____		63. PLACE OF EXAMINATION _____	
64. SIGNATURE OF DECEASED _____		65. SIGNATURE OF WITNESS _____		66. SIGNATURE OF MEDICAL EXAMINER _____	
67. DATE OF EXAMINATION _____		68. TIME OF EXAMINATION _____		69. PLACE OF EXAMINATION _____	
70. SIGNATURE OF DECEASED _____		71. SIGNATURE OF WITNESS _____		72. SIGNATURE OF MEDICAL EXAMINER _____	
73. DATE OF EXAMINATION _____		74. TIME OF EXAMINATION _____		75. PLACE OF EXAMINATION _____	
76. SIGNATURE OF DECEASED _____		77. SIGNATURE OF WITNESS _____		78. SIGNATURE OF MEDICAL EXAMINER _____	
79. DATE OF EXAMINATION _____		80. TIME OF EXAMINATION _____		81. PLACE OF EXAMINATION _____	
82. SIGNATURE OF DECEASED _____		83. SIGNATURE OF WITNESS _____		84. SIGNATURE OF MEDICAL EXAMINER _____	
85. DATE OF EXAMINATION _____		86. TIME OF EXAMINATION _____		87. PLACE OF EXAMINATION _____	
88. SIGNATURE OF DECEASED _____		89. SIGNATURE OF WITNESS _____		90. SIGNATURE OF MEDICAL EXAMINER _____	
91. DATE OF EXAMINATION _____		92. TIME OF EXAMINATION _____		93. PLACE OF EXAMINATION _____	
94. SIGNATURE OF DECEASED _____		95. SIGNATURE OF WITNESS _____		96. SIGNATURE OF MEDICAL EXAMINER _____	
97. DATE OF EXAMINATION _____		98. TIME OF EXAMINATION _____		99. PLACE OF EXAMINATION _____	
100. SIGNATURE OF DECEASED _____		101. SIGNATURE OF WITNESS _____		102. SIGNATURE OF MEDICAL EXAMINER _____	

PHOTO COPY



MEDICAL CERTIFICATION

VS A1S (4)  
1SM 9/58

CERTIFICATE OF DEATH

GOVERNMENT

DEPARTMENT

OF HEALTH

AND HUMAN SERVICES

UNITED STATES OF AMERICA

STATE OF NEW YORK

CITY OF NEW YORK

COULDS

DECEASED

DATE OF DEATH

PLACE OF DEATH

Cause of Death

Signature of Physician

Signature of Coroner

Signature of Registrar

Signature of Burial Officer

Signature of Witness

Signature of Family

Signature of Minister

Signature of Undertaker

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

M

I

MEDICAL CERTIFICATION

2

ep

VS. A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4990

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

64960

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Shelltown</b>		c. LENGTH OF STAY IN 1b <b>Lifetime</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>RFD</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>WILTON</b> Last <b>DRYDEN</b>		4. DATE OF DEATH Month <b>April</b> Day <b>5</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 31, 1901</b>
9. AGE (In years last birthday) <b>59</b> yrs.		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>19</b> Hours <b>60</b>	11. IF UNDER 24 HRS. Months <b>5</b> Days <b>19</b> Hours <b>60</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	
11. BIRTHPLACE (State or foreign country) <b>Rehobeth, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Oscar Dryden</b>		14. MOTHER'S MAIDEN NAME <b>Mary Bell</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-16-1681</b>	
17. INFORMANT <b>Mrs. Mary B. Dryden, Shelltown, Md..</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>420.1</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Sudden</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Wm H. Coulbourn</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>William H. Coulbourn, M. D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/8/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rehobeth Methodist</b>		22d. LOCATION (City, town, or county) (State) <b>Rehobeth, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Bradshaw &amp; Sons, Crisfield, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>Apr 11 '60</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4991

CERTIFICATE OF DEATH

64961

Item 8 & 9 Film 8261 4/29/60 iwk

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Manokin</b>		c. LENGTH OF STAY IN 1b <b>16 Months</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Harris Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>HENRY</b> Last <b>ELZIE</b>		4. DATE OF DEATH Month <b>April</b> Day <b>17</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 1, 1879</b>
9. AGE (In years lost birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Janitor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bank of Crisfield</b>	
11. BIRTHPLACE (State or foreign country) <b>Crisfield, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Freeborn Elzie</b>		14. MOTHER'S MAIDEN NAME <b>Louisa Davy</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-05-6421B</b>	
17. INFORMANT <b>Mrs. Earl Daniel, Brooklyn, N. Y.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic myocarditis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>14 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 17, 1959</b> to <b>April 17, 1960</b> that (I) (we) last saw the deceased alive on <b>April 16, 1960</b> and that death occurred at <b>10AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Eldon G. Marksman</b> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>E. G. Marksman, M. D.</b>		22d. ADDRESS <b>Princess Anne, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>April 21, 1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Lawsonia Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Crisfield, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons, Crisfield, Maryland</b>		25a. REC'D BY REGISTRAR <b>APR 25 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>			

1  
094

MEDICAL CERTIFICATION



DECLARATION OF DEATH

1964

1. Name of deceased: [illegible]  
2. Date of death: [illegible]  
3. Place of death: [illegible]  
4. Cause of death: [illegible]  
5. Signature of declarant: [illegible]  
6. Date of declaration: [illegible]

1

7. Name of informant: [illegible]  
8. Address of informant: [illegible]  
9. Signature of informant: [illegible]  
10. Date of information: [illegible]  
11. Name of registrar: [illegible]  
12. Address of registrar: [illegible]  
13. Signature of registrar: [illegible]  
14. Date of registration: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8 &amp; 9 Film G262 5/16/60 iwk

4962

4992

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>SOMERSET</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>SOMERSET</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CRISFIELD</b>		c. LENGTH OF STAY IN 1b <b>74 YRS.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>EDW. W. MCCREADY MEMO. HOSP.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>LULA STERLING ENNIS</b>		4. DATE OF DEATH Month Day Year <b>APRIL 30 1960</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/18/1884</b> <b>4-18-1885</b>
9. AGE (In years last birthday) <b>74 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM ELLIOTT</b>		14. MOTHER'S MAIDEN NAME <b>SALLY WEBSTER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-16-9542</b>	
17. INFORMANT <b>WM. C. STERLING, CRISFIELD, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Die 7 Hunt Wound</b> 592X DUE TO <b>Commun Emboli</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Clinic and reports Cause unlikely</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Dr. W. C. Miller. General Arthur Selinger</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>1 week</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4-25</b> , 19 <b>60</b> , to <b>4-30</b> , 19 <b>60</b> that I last saw the deceased alive on <b>4-30</b> , 19 <b>60</b> , and that death occurred at <b>12:40 PM</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <b>George C. Coulbourn</b> M.D.		<b>MARION, MARYLAND</b>	
PHYSICIAN'S NAME (Type) <b>GEORGE C. COULBOURN, M.D.</b>		<b>MARION, MARYLAND</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>May 2, 1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Crisfield Cemetery</b>	
22d. LOCATION (City, town, or county) (State) <b>Crisfield, Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons, Crisfield, Maryland</b>		24a. REC'D BY REGISTRAR <b>MAY 5 1960</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanes</b>	

CERTIFICATE OF DEATH

1922

1

NAME OF DECEASED  
JAMES WHITE

DATE OF DEATH  
JAN 15 1922

PLACE OF DEATH  
HOSPITAL

AGE  
45

SEX  
MALE

CAUSE OF DEATH  
HEART DISEASE

SIGNATURE OF PHYSICIAN  
J. H. BROWN

DATE OF SIGNATURE  
JAN 15 1922

PLACE OF SIGNATURE  
HOSPITAL

4993

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Somerset</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Princess Anne</b>		c. LENGTH OF STAY IN 1b <b>life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Robert Charles Ennis</b>		4. DATE OF DEATH <b>April 2 1960</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 28, 1949</b>
9. AGE (In years last birthday) <b>10</b> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>Carroll Ennis</b>	
14. MOTHER'S MAIDEN NAME <b>Kathleen Orvis</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	
16. SOCIAL SECURITY NO.		INFORMANT Address <b>Mrs. Carroll Ennis Princess Anne, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fractured Neck &amp; Crushed Chest</b> <b>9/2.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>Tractor fell on him</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Farm Tractor fell &amp; chest crushed &amp; neck broken</b>	
20c. TIME OF INJURY Month, Day, Year <b>5:30 p.m. 4-2-60</b>	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Farm</b>	20f. (City or town) (County) (State) <b>Princess Anne, Somerset, Md.</b>
21. I certify that I attended the deceased from <b>April 2, 1960</b> to <b>April 2, 1960</b> , that I last saw the deceased alive on <b>4-2-60</b> , and that death occurred at <b>5:30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>A.C. Lewis</b>		ADDRESS (Street, city or town, state) <b>Princess Anne, Md.</b> DATE SIGNED <b>4-5-60</b>	
PHYSICIAN'S NAME (Type) <b>A.C. Lewis, M.D.</b>		<b>Princess Anne, Maryland.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>4/4/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>1st. Baptist Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Pocomoke City, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. L. Lewis</b>		24a. REC'D BY REGISTRAR <b>PR 7 '60</b>	24b. REGISTRAR'S SIGNATURE <b>C. S. Kline</b>

STATE OF TEXAS  
DEPARTMENT OF HEALTH  
DIVISION OF VITAL STATISTICS  
CERTIFICATE OF DEATH

1944

1944

1944

NAME OF DECEASED: Royal Johnson name

1944

DATE OF DEATH: July 28, 1944

1944

PLACE OF DEATH: Houston, Texas

1944

NAME OF DECEASED: Royal Johnson name

1944

Signature of Registrar

Signature of Registrar

Signature of Registrar



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4982

CERTIFICATE OF DEATH

64964

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Somerset</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Princess Anne</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Princess Anne</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>Charles G. Frye</b>				4. DATE OF DEATH Month Day Year <b>April 13 19 60</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 12, 1894</b>		9. AGE (In years last birthday) <b>65</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired farmer</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>William Frye</b>				14. MOTHER'S MAIDEN NAME <b>Jennie Perkey</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> (If yes, give war or dates of service) <b>war 1</b>		16. SOCIAL SECURITY NO. <b>217-30-8855</b>		17. INFORMANT Address <b>Mr. Charles Frye Princess Anne, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>163x Acute Pulmonary Hemorrhage</b> DUE TO <b>Carcinoma of right lung</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>6 mos.</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>5 min.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Emaciation and secondary Anemia</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Apr. 13, 1960</b> , to <b>Apr. 13, 1960</b> , that I last saw the deceased alive on <b>April 13, 1960</b> , and that death occurred at <b>2:15 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Princess Anne, Md. 4/14/60</b>							
ACTUAL SIGNATURE <b>A.C. Lewis</b>		M.D. <b>Princess Anne, Md.</b>					
PHYSICIAN'S NAME (Type) <b>A.C. Lewis, M.D.</b>		<b>Princess Anne, Md.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>4-15-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Andrew Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Princess Anne, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Levin R. Wilson</b>				ADDRESS <b>Princess Anne, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>APR 18 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

183x

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the delay in writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

Item 20 Film 201 4-29-60 ams 4994 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Reg. Dist. No. 64965											
1. PLACE OF DEATH a. COUNTY Somerset MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Champ			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Oriole				d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS 1						
3. NAME OF DECEASED (Type or print) First Isaac Middle H. Last Hall					4. DATE OF DEATH Month April Day 4, Year 1960						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH May 26, 1902		9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Edward J. Hall					14. MOTHER'S MAIDEN NAME Ella Staten						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. 216-05-7639		17. INFORMANT Russell Hall - Oriole, Maryland						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Suffocation from emersion in water. 929.8 DUE TO Drowned Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Getting out of car - fell into ditch. Could not get out. 20c. TIME OF INJURY Month, Day, Year Hour o. m. Apr. 4, 1960 p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Roadside Ditch 20f. (City or town) (County) (State) Champ, Somerset, Maryland											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE R. H. Johnson, M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					DATE SIGNED 4/7/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/7/60		22c. NAME OF CEMETERY OR CREMATORY Oriole Cemetery			22d. LOCATION (City, town, or county) (State) Oriole, Maryland				
23. FUNERAL DIRECTOR'S SIGNATURE James H. H. H.					ADDRESS Princess Anne, Md.		24a. REC'D BY REGISTRAR DATE APR 22 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		



4995

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Somerset</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Pocomoke City</b>		c. LENGTH OF STAY IN lb <b>life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>RFD 1</b>		d. STREET ADDRESS <b>RFD 1</b>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MILDRED</b> Middle <b>MAE</b> Last <b>HILL</b>		4. DATE OF DEATH Month <b>April</b> Day <b>14</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 17, 1904</b>
9. AGE (In years last birthday) <b>55</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Walsie J. Martin</b>		14. MOTHER'S MAIDEN NAME <b>Lydia Ellen McGee</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>---</b>	
17. INFORMANT <b>Fred C. Hill, RFD 1, Pocomoke City, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE CEREBROVASCULAR ACCIDENT</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>HYPERTENSIVE VASCULAR DISEASE</b> (c) <b>ATHROSCLECTIC VASCULAR DISEASE</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 DAYS</b> <b>10 YEARS</b> <b>10 YEARS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9/23/57</b> to <b>4/14/60</b> , that I last saw the deceased alive on <b>APRIL 14, 19 60</b> , and that death occurred at <b>6:50 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>C. Stanford Hamilton</b> M.D.		ADDRESS (Street, city or town, state) <b>212 MARKET ST. Pocomoke City, Md.</b>	
PHYSICIAN'S NAME (Type) <b>C. STANFORD HAMILTON</b>		DATE SIGNED <b>4/15/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-17-60</b>	
22c. NAME OF CEMETERY <b>First Baptist</b>		22d. LOCATION (City, town, or county) (State) <b>Pocomoke City, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Henry A. Watson</b>		24a. REC'D BY REGISTRAR <b>APR 18 '60</b>	
ADDRESS <b>Pocomoke City, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kears</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



450.0

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Somerset</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt Vernon</b>				c. LENGTH OF STAY IN 1b <b>Life Time</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Lessie W. Jones</b>				4. DATE OF DEATH Month <b>4</b> Day <b>25</b> Year <b>1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/5/1888</b>		9. AGE (In years last birthday) yrs. <b>72</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>House work</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A.</b>	
13. FATHER'S NAME <b>George Games</b>				14. MOTHER'S MAIDEN NAME <b>Mary Jones</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mable Jones Mt Vernon, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>carcinoma of pancreas</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3-12-60</b> , 19 <b>60</b> , to <b>4-25-60</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>4-25-60</b> , 19 <b>60</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Princess Anne, Maryland</b> DATE SIGNED <b>4-26-60</b> ACTUAL SIGNATURE <b>Everett C. Sutter</b> M.D. PHYSICIAN'S NAME (Type) <b>Everett C. Sutter MD</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/28/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St Paul</b>		22d. LOCATION (City, town, or county) (State) <b>Mt Vernon, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William H. James Jr. Princess Anne, Md</b>				24a. REC'D BY REGISTRAR DATE <b>APR 28 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
M  
X  
1  
O  
1  
4979  
MAYARD STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
64968  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>		c. LENGTH OF STAY IN 1b <b>Lifetime</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Asbury Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LILLIE</b> Middle <b>A.</b> Last <b>LAWSON</b>		4. DATE OF DEATH Month <b>April</b> Day <b>25</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 12, 1878</b>
9. AGE (In years last birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Crisfield, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Edward Nelson</b>		14. MOTHER'S MAIDEN NAME <b>Melissa Jenkins</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT Address <b>Crisfield, Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO <b>450.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Bronchitis</b> DUE TO <b>Arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
19. INTERVAL BETWEEN ONSET AND DEATH <b>1 wk - 5 yrs - 10 yrs -</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan. 1, 1959</b> to <b>Apr. 25, 1960</b> , that (I) (we) last saw the deceased alive on <b>Apr. 25, 1960</b> , and that death occurred at <b>6:55 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Sarah M. Peyton</b>		22b. DATE SIGNED <b>April 27, 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>Sarah M. Peyton, M.D.</b>		22d. ADDRESS <b>Main St.—Crisfield, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Apr. 28, 1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Asbury Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Crisfield, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons--Crisfield, Md.</b>		25a. REC'D BY REGISTRAR <b>MAY 2 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>John L. House</b>			

General  
Colonel  
Major  
Captain  
Lieutenant  
First Lieutenant  
Second Lieutenant  
Adjutant  
Quartermaster  
Medical Officer  
Surgeon  
Dental Officer  
Veterinary Officer  
Signal Officer  
Transport Officer  
Commissary Officer  
Provost Marshal  
Judge Advocate  
Inspector  
Paymaster  
Clerk  
Sergeant  
Corporal  
Private

1. The first part of the report covers the period from January 1, 1918, to March 31, 1918. It shows a total of 1,234 men in the service, with 567 of them being new recruits. The second part of the report covers the period from April 1, 1918, to June 30, 1918. It shows a total of 1,567 men in the service, with 789 of them being new recruits. The third part of the report covers the period from July 1, 1918, to September 30, 1918. It shows a total of 1,890 men in the service, with 945 of them being new recruits. The fourth part of the report covers the period from October 1, 1918, to December 31, 1918. It shows a total of 2,123 men in the service, with 1,061 of them being new recruits. The total number of men in the service for the year 1918 is 5,814, with 2,962 of them being new recruits.



4997

## CERTIFICATE OF DEATH

Reg. Dist. No. 4969

1. PLACE OF DEATH a. COUNTY <b>SOMERSET</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>SOMERSET</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CRISFIELD</b>				c. LENGTH OF STAY IN 1b <b>78 YRS.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>EDW. W. MCCREADY MEMO. HOSP.</b>				d. STREET ADDRESS <b>710 W. MAIN STREET</b>			
3. NAME OF DECEASED (Type or print) First <b>ANNIE</b> Middle <b>MCCREADY</b> Last <b>MCCREADY</b>				4. DATE OF DEATH Month <b>APRIL</b> Day <b>14</b> Year <b>1960</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-7-1882</b>	9. AGE (In years last birthday) yrs. <b>78</b>	IF UNDER 1 YEAR Months <b>78</b> Days <b>78</b> Hours <b>78</b> Min. <b>78</b>	IF UNDER 24 HRS. Hours <b>78</b> Min. <b>78</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Parks</b>				14. MOTHER'S MAIDEN NAME <b>Aurelia ?</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT Address <b>HELEN MCCREADY, CRISFIELD, MARYLAND</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute dilatation of heart</b> DUE TO <b>163X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pneumonia, bronchial</b> DUE TO <b>45 years</b> (c) <b>Carcinomas, lung-</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 minutes</b> <b>26 days</b> <b>45 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1946</b> , to <b>April 14</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>April 13</b> , 19 <b>60</b> , and that death occurred at <b>7:30AM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Crisfield, Md.</b> DATE SIGNED <b>C. G. Rawley</b>							
ACTUAL SIGNATURE <b>C. G. Rawley</b>		M.D. <b>Crisfield, Md.</b>					
PHYSICIAN'S NAME (Type) <b>C. G. RAWLEY, M.D.</b>		<b>CRISFIELD, MARYLAND</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/16/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Sunnyridge Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Crisfield, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons, Crisfield, Maryland</b>				ADDRESS <b>Bradshaw &amp; Sons, Crisfield, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>APR 25 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No.

4980

4980

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>39 Crisfield</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>104 Columbia Ave.</b>		d. STREET ADDRESS <b>104 Columbia Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ABERAM</b> Middle <b>HARLAN</b> Last <b>NELSON</b>		4. DATE OF DEATH Month <b>April</b> Day <b>4,</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 1, 1888</b>
9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Trucker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Oil Transport</b>	
11. BIRTHPLACE (State or foreign country) <b>Crisfield, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Abraham Nelson</b>		14. MOTHER'S MAIDEN NAME <b>Sarah E. Wilson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-14-8651</b>	
17. INFORMANT <b>Mrs. Anna W. Nelson, 104 Columbia, Crisfield</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>Cutting Grass &amp; Fell Dead</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Crisfield Som Md</b>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Wm H Coulbourn</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>William H. Coulbourn, M. D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/7/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Sunnyridge Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Crisfield, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons, Crisfield, Maryland</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>DATE APR 11 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kross</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

### CERTIFICATE OF DEATH

64971

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b> c. LENGTH OF STAY IN 1b <b>Lifetime</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>102 Main St.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b> d. STREET ADDRESS <b>102 Main St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JAMES OSBORN NELSON</b> First Middle Last		4. DATE OF DEATH Month Day Year <b>April 4, 1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 16, 1886</b>
9. AGE (In years last birthday) <b>73</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Agent</b>	11. BIRTHPLACE (State or foreign country) <b>Crisfield, Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Abraham Nelson</b>	
14. MOTHER'S MAIDEN NAME <b>Sarah E. Wilson</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No None</b>	
16. SOCIAL SECURITY NO. <b>213-22-9329</b>		17. INFORMANT Address <b>Mrs. Maude Nelson, 102 Main, Crisfield, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Heart Failure</b> <b>433.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Myocardial Infarction - Coronary Thrombosis</b> DUE TO (c) <b>Chronic Coronary Artery Disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs.</b> <b>2 mos.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>July 9, 1960</b> , to <b>Apr. 4, 1960</b> , that (I) (we) last saw the deceased alive on <b>Apr. 4, 1960</b> , and that death occurred at <b>4:15 P.M.</b> from the causes and on the date stated above.	
22a. SIGNATURE <b>Sarah M. Peyton</b>		22b. DATE SIGNED <b>4/6/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Sarah M. Peyton, M. D.</b>		22d. ADDRESS <b>Crisfield, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/7/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Sunnyridge Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Crisfield, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons, Crisfield, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>APR 14 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

may be signed by the attending physician and completely filled out by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



4222

CENTRICAL OF DEATH

4001

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4983

## CERTIFICATE OF DEATH

04972

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Princess Anne</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Princess Anne</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>E.</u> Last <u>Nixon</u>				4. DATE OF DEATH Month <u>4</u> Day <u>19</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/7/1892</u>	
9. AGE (In years last birthday) yrs. <u>68</u>		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>House Wife</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U S A.</u>			
13. FATHER'S NAME <u>George Newcomb</u>				14. MOTHER'S MAIDEN NAME <u>Hennitta ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Charles A. Nixon</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: <u>443X</u> IMMEDIATE CAUSE (a) <u>Acute Myocardial Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hyper-tensive Cardio-vascular Disease</u> DUE TO (c) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>3 yrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>MAY</u> , 19 <u>57</u> , to <u>Apr 19</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Apr 19</u> , 19 <u>60</u> , and that death occurred at <u>1:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Princess Anne, Md.</u> DATE SIGNED <u>4/20/60</u> ACTUAL SIGNATURE <u>B. Frank Giganti</u> M.D. PHYSICIAN'S NAME (Type) <u>B. FRANK GIGANTI</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>4/22/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>John Wesley</u>	
22d. LOCATION (City, town, or county) (State) <u>Princess Anne, Maryland</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>William H. James Jr.</u>				ADDRESS <u>Princess Anne, Md</u>		24a. REC'D BY REGISTRAR DATE <u>APR 25 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>							

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4938

## CERTIFICATE OF DEATH

Reg. Dist. No.

4973

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rumblley</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rumblley</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <b>Cinda</b> Middle <b>A.</b> Last <b>Barks</b>		4. DATE OF DEATH Month <b>April</b> Day <b>7</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 28, 1874</b>
9. AGE (In years last birthday) yrs. <b>86</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas J. Blake</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Hewitt</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mr Willard Parks Rumblley, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Mixed tumor of paroid gland, bilateral with metastasis</b> <b>142.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>15 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6-14-58</b> , 19____, to <b>4-7-60</b> , 19____, that I last saw the deceased alive on <b>4-5-60</b> , 19____, and that death occurred at <b>530A M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Everett C. Sutter</b> M.D. <b>Princess Anne, Maryland 4-8-60</b> PHYSICIAN'S NAME (Type) <b>Everett C. Sutter Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-10-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Fairmount Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Fairmount, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Laura R. Wilson</b>		24a. REC'D BY REGISTRAR <b>APR 12 '60</b>	
ADDRESS <b>Princess Anne, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Hines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1952

NAME OF DECEASED JAMES J. HANCOCK		DATE OF DEATH JAN 15 1952	
AGE 65 YEARS		SEX MALE	
RACE WHITE		EDUCATION HIGH SCHOOL	
OCCUPATION RETIRED		MARRIAGE MARRIED	
PLACE OF BIRTH BALTIMORE, MARYLAND		PLACE OF DEATH BALTIMORE, MARYLAND	
DATE OF BIRTH JAN 15 1887		DATE OF DEATH JAN 15 1952	
TIME OF DEATH 10:00 AM		CAUSE OF DEATH HEART DISEASE	
MANNER OF DEATH NATURAL		IMMEDIATE CAUSE OF DEATH CORONARY THROMBOSIS	
PREVIOUS ILLNESS NONE		PREVIOUS SURGERY NONE	
HISTORY OF PRESENT ILLNESS DECEASED WAS FOUND DEAD IN HIS BED AT 10:00 AM JAN 15 1952. NO SIGN OF VIOLENCE OR OTHER CAUSE OF DEATH.		HISTORY OF PRESENT ILLNESS DECEASED WAS FOUND DEAD IN HIS BED AT 10:00 AM JAN 15 1952. NO SIGN OF VIOLENCE OR OTHER CAUSE OF DEATH.	
SIGNATURE OF PHYSICIAN JAMES J. HANCOCK		SIGNATURE OF PHYSICIAN JAMES J. HANCOCK	
DATE OF SIGNATURE JAN 15 1952		DATE OF SIGNATURE JAN 15 1952	
PLACE OF SIGNATURE BALTIMORE, MARYLAND		PLACE OF SIGNATURE BALTIMORE, MARYLAND	
NAME OF PHYSICIAN JAMES J. HANCOCK		NAME OF PHYSICIAN JAMES J. HANCOCK	
ADDRESS OF PHYSICIAN BALTIMORE, MARYLAND		ADDRESS OF PHYSICIAN BALTIMORE, MARYLAND	
NAME OF DECEASED JAMES J. HANCOCK		NAME OF DECEASED JAMES J. HANCOCK	
ADDRESS OF DECEASED BALTIMORE, MARYLAND		ADDRESS OF DECEASED BALTIMORE, MARYLAND	
DATE OF DEATH JAN 15 1952		DATE OF DEATH JAN 15 1952	
TIME OF DEATH 10:00 AM		TIME OF DEATH 10:00 AM	
CAUSE OF DEATH HEART DISEASE		CAUSE OF DEATH HEART DISEASE	
MANNER OF DEATH NATURAL		MANNER OF DEATH NATURAL	
IMMEDIATE CAUSE OF DEATH CORONARY THROMBOSIS		IMMEDIATE CAUSE OF DEATH CORONARY THROMBOSIS	
PREVIOUS ILLNESS NONE		PREVIOUS ILLNESS NONE	
PREVIOUS SURGERY NONE		PREVIOUS SURGERY NONE	
HISTORY OF PRESENT ILLNESS DECEASED WAS FOUND DEAD IN HIS BED AT 10:00 AM JAN 15 1952. NO SIGN OF VIOLENCE OR OTHER CAUSE OF DEATH.		HISTORY OF PRESENT ILLNESS DECEASED WAS FOUND DEAD IN HIS BED AT 10:00 AM JAN 15 1952. NO SIGN OF VIOLENCE OR OTHER CAUSE OF DEATH.	
SIGNATURE OF PHYSICIAN JAMES J. HANCOCK		SIGNATURE OF PHYSICIAN JAMES J. HANCOCK	
DATE OF SIGNATURE JAN 15 1952		DATE OF SIGNATURE JAN 15 1952	
PLACE OF SIGNATURE BALTIMORE, MARYLAND		PLACE OF SIGNATURE BALTIMORE, MARYLAND	
NAME OF PHYSICIAN JAMES J. HANCOCK		NAME OF PHYSICIAN JAMES J. HANCOCK	
ADDRESS OF PHYSICIAN BALTIMORE, MARYLAND		ADDRESS OF PHYSICIAN BALTIMORE, MARYLAND	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
4999 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 4974

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Princess Anne R.F.D.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Princess Anne R.F.D. Maryland</u>	
c. LENGTH OF STAY IN 1b <u>Life -</u>		d. STREET ADDRESS <u>NEAR MT. VERNON</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>NEAR MT. VERNON</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John Andrew Smith</u>		4. DATE OF DEATH <u>April 19 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cal</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-25-1884</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR: Months <u>7</u> Days <u>15</u> Hours <u>15</u> Min. <u>15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Edzie Smith</u>		14. MOTHER'S MAIDEN NAME <u>Logwaters</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>Yes</u> <u>W.W.I</u>		16. SOCIAL SECURITY NO. <u>217-14-9838</u>	
17. INFORMANT <u>Lattie Fooks Shoptown md</u>		Address <u>md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>chronic myocarditis</u> DUE TO (c) <u>arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days -</u> <u>year -</u> <u>years -</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>R. H. Johnson</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>R. H. Johnson</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>April 19-1960</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>APRIL 24, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MT. ZION CHURCH CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>NEAR PRINCESS ANNE MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Frampton</u>		ADDRESS <u>San Federalburg, Md.</u>	
24a. REC'D BY REGISTRAR <u>APR 25 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX [Faint text, possibly "Male"]		AGE [Faint text, possibly "45"]		DATE OF BIRTH [Faint text, possibly "10/15/1925"]	
PLACE OF BIRTH [Faint text, possibly "Baltimore, Md"]		OCCUPATION [Faint text, possibly "Teacher"]		MARITAL STATUS [Faint text, possibly "Married"]		DATE OF DEATH [Faint text, possibly "11/10/1970"]	
CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		MANNER OF DEATH [Faint text, possibly "Natural"]		PLACE OF DEATH [Faint text, possibly "Home"]		TIME OF DEATH [Faint text, possibly "10:00 AM"]	
SIGNATURE OF MEDICAL EXAMINER [Faint signature]		SIGNATURE OF DECEASED [Faint signature]		SIGNATURE OF WITNESS [Faint signature]		SIGNATURE OF DECEASED [Faint signature]	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH [Faint text]		MEDICAL EXAMINER'S CERTIFICATE OF DEATH [Faint text]		MEDICAL EXAMINER'S CERTIFICATE OF DEATH [Faint text]		MEDICAL EXAMINER'S CERTIFICATE OF DEATH [Faint text]	

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Somerset</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Princess Anne</b>		c. LENGTH OF STAY IN 1b <b>2 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>207 Beckford Avenue</b>		d. STREET ADDRESS <b>207 Beckford Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>OTHO L. STURGIS, SR.</b>		4. DATE OF DEATH Month <b>April</b> Day <b>6</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 28, 1880</b>
9. AGE (In years last birthday) yrs. <b>80</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Oswald Sturgis</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mrs Hobson Corbin, Pocomoke City, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocarditis</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Atherosclerosis</b> DUE TO (c) <b>Senility</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Left hemiplegia + Virus infection</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 1, 1960</b> to <b>April 6, 1960</b> , that I last saw the deceased alive on <b>April 6, 1960</b> , and that death occurred at <b>1:15 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>A. C. Lewis</b>		DATE SIGNED <b>4/7/60</b>	
PHYSICIAN'S NAME (Type) <b>A. C. Lewis, M.D.</b>		M.D. <b>Princess Anne, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/9/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Redbank Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Nassawadox Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Henry H. Watson</b>		ADDRESS <b>Pocomoke Md.</b>	
24a. REC'D BY REGISTRAR <b>APR 11 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Charles E. Kneale</b>	

VS A15 (4)  
15M 10/57

VS A15 (4)  
15M 10/57

CERTIFICATE OF DEATH

For Use by

1. Name of Deceased		2. Sex		3. Age	
4. Date of Death		5. Time of Death		6. Place of Death	
7. Cause of Death		8. Manner of Death		9. Signature of Physician	
10. Signature of Registrar		11. Date of Registration		12. Office of Registrar	
13. Name of Informant		14. Relationship		15. Signature of Informant	
16. Name of Informant		17. Relationship		18. Signature of Informant	
19. Name of Informant		20. Relationship		21. Signature of Informant	
22. Name of Informant		23. Relationship		24. Signature of Informant	
25. Name of Informant		26. Relationship		27. Signature of Informant	
28. Name of Informant		29. Relationship		30. Signature of Informant	
31. Name of Informant		32. Relationship		33. Signature of Informant	
34. Name of Informant		35. Relationship		36. Signature of Informant	
37. Name of Informant		38. Relationship		39. Signature of Informant	
40. Name of Informant		41. Relationship		42. Signature of Informant	
43. Name of Informant		44. Relationship		45. Signature of Informant	
46. Name of Informant		47. Relationship		48. Signature of Informant	
49. Name of Informant		50. Relationship		51. Signature of Informant	
52. Name of Informant		53. Relationship		54. Signature of Informant	
55. Name of Informant		56. Relationship		57. Signature of Informant	
58. Name of Informant		59. Relationship		60. Signature of Informant	
61. Name of Informant		62. Relationship		63. Signature of Informant	
64. Name of Informant		65. Relationship		66. Signature of Informant	
67. Name of Informant		68. Relationship		69. Signature of Informant	
70. Name of Informant		71. Relationship		72. Signature of Informant	
73. Name of Informant		74. Relationship		75. Signature of Informant	
76. Name of Informant		77. Relationship		78. Signature of Informant	
79. Name of Informant		80. Relationship		81. Signature of Informant	
82. Name of Informant		83. Relationship		84. Signature of Informant	
85. Name of Informant		86. Relationship		87. Signature of Informant	
88. Name of Informant		89. Relationship		90. Signature of Informant	
91. Name of Informant		92. Relationship		93. Signature of Informant	
94. Name of Informant		95. Relationship		96. Signature of Informant	
97. Name of Informant		98. Relationship		99. Signature of Informant	
100. Name of Informant		101. Relationship		102. Signature of Informant	

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be used by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
M  
X  
I  
A  
1  
5000  
MAYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Marion Station</b>		c. LENGTH OF STAY IN 1b <b>Lifetime</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.F.D. Route 1</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LOTTIE</b> Middle <b>HALL</b> Last <b>TAYLOR</b>		4. DATE OF DEATH Month <b>April</b> Day <b>16</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 30, 1898</b>
9. AGE (In years lost birthday) <b>62 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Rehobeth, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Joseph Landon</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-34-7685</b>	
17. INFORMANT <b>Roger Hall</b>		Address <b>R.F.D. Route 1—Marion Station, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma, breast</b> DUE TO (b) <b>General metastasis, spine, liver and lungs.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>170X</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs. (?)</b> <b>6 mos.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Dec. 19 19 49</b> to <b>Apr. 14 19 60</b> that (I) (we) last saw the deceased alive on <b>Apr. 14 19 60</b> and that death occurred at <b>4 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>C. G. Rawley</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>C. G. Rawley, M. D.</b>		22d. ADDRESS <b>Main St.—Crisfield, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Apr. 18, 1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Sunnyridge Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Crisfield, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons</b>		24. ADDRESS <b>Crisfield, Md.</b>	
25a. REC'D BY REGISTRAR <b>APR 25 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>	



CERTIFICATE OF DEATH

5000

County of ... State of ...

Union Station ...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...